Modifier Coding Alert

Use Separate Services, Not Diagnoses, to Drive E/M-25 Decision

Without E/M components separate from the procedure, you can't report E/M-25.

When a provider performs a procedure and a significant, separately identifiable E/M service during the same encounter, modifier 25 is your best friend.

You'll use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) on your E/M codes most commonly when the provider:

- Performs a procedure and treats an entirely different problem with an E/M during the same encounter.
- Performs a procedure along with a separate E/M related to the procedure.

Sharpen your E/M-25 identification skills with these case studies, which drill down into details revealing best practices for reporting each of these common modifier 25 claims.

Case Study: 2 Services for Different Problems

If a patient has a pair of unrelated problems that the provider treats during the same encoutner, be sure that the claim specifics reflect the different maladies, confirms **Jean Acevedo, LHRM, CPC, CHC, CENTC**, president and senior consultant with Acevedo Consulting Incorporated in Delray Beach, Fla.. Consider this case study:

Encounter: An established patient reports for a scheduled follow-up appointment to monitor her type 2 diabetes. During the encounter, the patient complains of increasing left knee pain. The provider diagnoses the patient with osteoarthritis. After a level-three E/M service for the patient's diabetes, the provider performs arthrocentesis without guidance to treat her knee pain.

Coding: On the claim, you would report 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; without ultrasound guidance) for the injection with modifier LT (Left side) appended, if the payer requires it. Then, you'd report 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity) for the E/M with modifier 25 appended to show that the diabetes check and knee injection were separate services.

Attach E11.9 (Type 2 diabetes mellitus without complications) to 99213 to represent the patient's diabetes and M17.12 (Unilateral primary osteoarthritis, left knee) to 20610 to represent the patient's osteoarthritis.

The '25 test': To ensure that you are indeed coding for two separate problems, separate the procedure notes from the E/M notes, and then check if you can support codes for two services. "There should be unique documentation to support each service" in the encounter notes, Acevedo explains.

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If you printed out the encounter note for the above example, and cut out the documentation supporting arthrocentesis, Acevedo says you should be able to identify all the components of a separate E/M with the remaining documentation.

Case Study: 2 Services for the Same Problem

Encounter notes might warrant a procedure and a separate E/M-25 when the patient reports with different problems, but you'll likely need more detailed documentation when the procedure and E/M are for the same problem, warns **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** internal audit manager with PeaceHealth in Vancouver, Wash. "There must be documentation that the history, examination, and decision-making involved was more than just the simple decision prior to the procedure," Bucknam explains. This will usually result in a higher level E/M service that goes beyond the procedure that the provider eventually performs.

Myth: You must have a different diagnosis code for each service when reporting E/M-25. A different diagnosis often makes the claim go through more successfully, but it is not a requisite. However, the notes must clearly indicate that the E/M dealt with issues that were not part of the other procedure.

Encounter: An established patient presents with a laceration of the scalp that he suffered during a fall; he reports that he lost consciousness briefly after the fall. Notes indicate an examination of the skin laceration, and an exam for possible underlying skull fractures and neurologic status. The physician diagnoses a concussion, but identifies no further neurologic concerns. Notes indicate that the E/M visit included a detailed history and exam, and moderate medical decision-making. In addition to the head exam, the E/M service includes the decision to close the scalp laceration. The provider performs simple closure of a 1 cm wound on the patient's scalp.

Coding: First, report 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.5 cm or less) for the laceration repair with S01.01XA (Laceration without foreign body of scalp, initial encounter) appended to represent the patient's wound. Then, report 99214 (... a detailed history; a detailed examination; medical decision making of moderate complexity) with modifier 25 appended to show that the E/M was a separate service from the wound closure. Remember to append S01.01XA and S06.0X1A (Concussion with loss of consciousness of 30 minutes or less, initial encounter) to 99214 to represent the laceration and the concussion, respectively.

On this claim, a high-level E/M was necessary to check for head trauma, but the ensuing procedure was relatively minor. In order to get paid for both services on this claim, "there must be documentation that the history, examination, and decision making was more than just the simple decision prior to the procedure [laceration repair]," Bucknam explains.

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